Centers for Medicare and Medicaid Services (CMS)
Long Term Care Resident Assessment Instrument
RAI Version 2.0 Questions and Answers

Preface

This Question and Answer document contains responses to 90 Resident Assessment Instrument (RAI) Version 2.0 questions, directed to the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration. The document begins with general questions about the RAI process. The remaining questions are then arranged by alphabetic section of the RAI form.

This is the third Question and Answer compilation document for version 2.0 formally published by CMS. As such, the question/response sets in this document are numbered 3 – 1 through 3 – 90. The first compilation document was published as "MDS 2.0 Q & A Guide", in August 1996. The second was published as "MDS 2.0 Q & A Addendum", in March 2001. The third was published as "MDS 2.0 Q & A Addendum 2", in July 2001. All three Q & A compilations, as well as individual sets of Q & A's linked to CMS satellite broadcasts, can be downloaded from the CMS web site at:

www.hcfa.gov/medicaid/mds20/res_man.htm

In addition to the Q & A's, *use of the Item coding instructions in the RAI User's Manual is essential to accurate MDS coding*.

These Q & A's respond to MDS-related inquiries and comments received from a variety of sources, including: 1) inquiries from State and Regional Office staff; 2) results of recent OIG reports; 3) observations from testing new MDS Accuracy Protocols in 30 facilities; and 4) a CMS-sponsored industry-wide survey, which invited questions and comments from the National Provider and Consumer Organizations (i.e., AHCA, AAHSA, AANAC and NCCNHR), from the MDS software vendor community, and from State and Regional Office representatives.

The publication of these Q & A's is only one of a variety of CMS initiatives underway to improve and promote MDS accuracy. Other short-term initiatives include a review of MDS coding instructions at our national RAI conference; revising the RAI User's Manual to incorporate both the Q & A's and new policy implemented since the last publication of the RAI User's Manual in 1995; and the development of MDS Accuracy Protocols for use by a Program Safeguard Contractor in analyzing and verifying MDS data. For the longer term, we are looking at ways to refine the MDS in a way that addresses overall length, clarity, accuracy and clinical utility, for future implementation. In addition, we continue to work with RAI and MDS Automation Coordinators in every State on an on-going basis. These 'local' experts are available to answer MDS related questions.

This Q & A compilation is published by CMS and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective assessment practices in long term care facilities. This is an adjunct to the Long Term Care RAI User's Manual, Version 2.0, Oct. 1995.

A copy of CMS' Long Term Care Resident Assessment Instrument User's Manual Version 2.0 can be downloaded for free from the CMS web site at:
www.hcfa.gov/medicaid/mds20/man-form.htm
The manual is listed as "MDS 2.0 Training Manual", filename manual.exe. Due to the format and size of this file, printing the User's Manual may be complicated and time consuming. It may be easiest to purchase a bound copy. Bound copies can be purchased for $84.00 (plus s + h), from National Technical Information Services, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161, tel. (800)-553-6847, order publication number PB-96-109053. Bound copies are also sold by various national associations, and by commercial vendors of forms and manuals.

The Q & A's in this document were developed by CMS Central Office staff: Cindy Hake, Dana Burley, Sheila Lambowitz, and Jeane Nitsch; with editorial review by CMS staff: Lisa Hines, Yael Harris, Dorothea Musgrave and Rosalind Abankwah, Pharm.D. Special thanks are given to Dr. John Morris, Dr. Katharine Murphy, and Pauline Belleville-Taylor of the Hebrew Rehabilitation Centre for the Aged; and to Dr. Bob Godbout of Stepwise Systems, Helen Deere-Powell, Pharm.D., (CMS expert consultant), Carmen Bowman (Colorado State Agency), and Sheri Kennedy of Knowledge Solutions, for their input on these materials.

Please refer any additional MDS clinical or coding questions to the RAI Coordinator in your State, and any additional questions regarding MDS automation and electronic transmission to the MDS Automation Coordinator in your State. A list of State RAI and MDS Automation Coordinators, including contact information, is published on the CMS website at:
www.hcfa.gov/medicaid/mds20/state.htm/

MDS Questions that cannot be resolved at the State level should be referred by the State to the CMS Regional Office RAI Coordinator. MDS Questions that cannot be resolved at the Regional level should be referred by the Regional Office to the CMS Central Office: MDS Coordinator
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-12-25
Baltimore, MD 21244

PPS questions should be referred to the facility's Medicare Fiscal Intermediary.

Thank you for your continued enthusiasm in implementing the RAI version 2.0.

General Questions about the RAI Process

QUESTION 3 - 1: Is it necessary to actually observe and physically assess the resident, conduct family interviews, staff interviews, etc., every time we perform an MDS assessment? Most of our residents have been with us for several years, as has the staff, so we really know how our residents' status.

It is important to observe, interview and physically assess the resident, and to interview staff. In addition, the MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

QUESTION 3 - 2: During orientation to my position I was told that I could answer the questions on the MDS by looking at the clinical record. Recently someone mentioned that I should interview staff from all shifts. Which is correct?

Review the RAI Users' Manual Version 2.0, pg. 2 – 19, 20. Assessors must capture the resident's actual status and performance, and what care was actually provided during the entire observation period. This includes gathering information from a variety of staff and/or gathering information across shifts, when indicated by the MDS Item coding instructions. Not every nuance will be documented in the clinical record. Therefore it's important to obtain information from the residents and direct care givers. To code the MDS accurately, multiple sources of information must be used, such as: interview, observation and assessment of the resident, communication with direct care staff and other disciplines working with the resident, contact with family, and clinical record review. It is not necessary that one assessor must do all of this him/herself. It's up to the facility to establish systems, policies and procedures to facilitate the RAI processes, and accurate MDS coding.

QUESTION 3 - 3: If an Item does not trigger, or has no associated trigger, but is viewed by the interdisciplinary team as a resident problem, is there a requirement to care plan for that problem?

Yes. The RAI was not designed to identify every conceivable problem that a resident might experience. An example of this is "chewing problem" at MDS Item K1a. Although the resident might have a chewing problem, checking this problem does not trigger a RAP. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care.

In ensuring that a resident's care plan is unique and specific to the resident, it is not sufficient to rely solely on the triggered RAPs.

QUESTION 3 - 4: Can a facility use the therapy evaluation done in the hospital to start the SNF therapy plan of care?

No. The beneficiary's needs and goals during an acute care hospital stay are not necessarily the same as those that will be established during the SNF stay. Although the physician and therapist should review the hospital evaluation if available, the therapist MUST perform a full evaluation of the beneficiary as he/she presents in the facility. The plan of treatment is then developed by the physician and the therapist to address the beneficiary's needs and goals during the post-acute stay at the SNF.

QUESTION 3 - 5: In the Medicare Prospective Payment System (PPS) Final Rule, as well as in the State Operations Manual (SOM), reference is made to a "look-back" period. Reference is also made in PPS documents to an "assessment period". Are the "look-back" and "assessment period" the same as the "observation period"?

Yes. The observation period, as defined in the CMS Long Term Care Resident Assessment Instrument User's Manual Version 2.0, pg. 3-29 – 3-31, is the same as the look-back and the assessment periods. It is the time period during which data may be captured for inclusion in an MDS assessment. The last day of the observation period is the Assessment Reference Date (the date recorded at MDS Item A3a).

QUESTION 3 - 6: Is the observation period always 7 days for every Item on the MDS?

No. The observation period varies by Item. It can be as short as 3 days, (e.g. MDS Item J1d), or as long as 180 days (e.g. MDS Items J4b, c and d). When the observation period is not indicated on the form at the specific MDS Section or Item, use a 7-day observation period. Note the statement at the top of the MDS form "status in the last 7 days, unless other time frame indicated". Regardless of the length of the observation period, it always ends on the assessment reference date, (the date recorded at MDS Item A3a).

QUESTION 3 - 7: We discovered an assessment that was signed and dated by all assessors, but not by the RN Coordinator. The RN Coordinator employed at the time of that assessment is no longer at the facility. Can the new RN Coordinator sign the assessment at MDS Item R2a?

Yes. If all individual assessors have signed the assessment, and attested to it's accuracy, all that remains is for the RN Coordinator to review for completeness, and sign and date the assessment at Items R2a and b. The date at R2b must be the date the RN Coordinator actually signed the form. Backdating is not permissible.

QUESTION 3 - 8: Please clarify the signature and date requirements for assessments that are printed after being encoded in the computer. Specifically, when we take the allowed 7 days to encode the data in the computer, what date should we use on the printed assessment?

Each assessment must be completed, and a paper copy signed, within the federally mandated timeframe, whether this is a hand written or a computer generated form. For example, an initial admission assessment must be completed through MDS Item VB2, signed and dated, no later than day 14 of the stay. An additional 7 days after completion are allowed to encode, edit, and correct the assessment. Any corrections during this period must be made to the electronic and the paper records in the facility. It may also be appropriate to update the resident's care plan, based on the revised assessment record. To make the correction on the paper form, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry. CMS has published this information in the State Operations Manual, page R-161. It is also published in CMS' "Draft Provider Instructions for making Automated Corrections Using the New MDS Correction Request Form", page 2-12, under the heading "Assessment Error Detected During the 7 Day Editing Period".

QUESTION 3 - 9: I thought we had 7 days after an assessment was completed to correct any errors and encode an assessment. In our facility, we print and sign the assessment by day 14. Does this mean that we lose that "additional 7 days"?

An additional 7 days following completion are always available for the facility to edit and correct the assessment. If an assessment is printed and then signed as complete by day 14, then you do not lose the additional 7 days after completion for editing and correcting the assessment.

QUESTION 3 - 10: Must a facility maintain both the hand written and computer-generated MDS forms on the resident's clinical record? If not, which is preferred?

Not every facility prints computer generated resident assessment records. In some facilities, the records are manually completed. There is no requirement to maintain two copies of the form in the resident's record. Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed and dated within the regulatory timeframes, and maintained for 15 months in the resident's active record. If changes are made after completion, those changes must be made to the electronic record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment record. Resident assessment forms must accurately reflect the resident's status, and agree with the record that is submitted to the CMS standard system at the State. For additional information, refer to Resident Assessment Requirements for Long Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.

QUESTION 3 - 11: Is it permissible to use electronic signatures for RAI forms and maintain RAI records only in electronic format?

Until such time as the agency adopts an electronic signature standard that is compatible with pending Heath Insurance Standards and Accountability Act (HIPAA) requirements for electronic signature, all facilities are required to sign and retain hard copies of MDS forms. We understand that the industry is eager to use electronic signatures, and we are just as eager to enable that capability. We plan to implement this as soon as the agency adopts an electronic signature standard, and the standard system is upgraded to enable compliance.

Questions on Items in MDS Section AA of the Basic Assessment Tracking Form, Including Questions Related to Reasons for Assessment, Timing and Frequency Requirements, RUG-III and Medicare Billing

QUESTION 3 - 12: How is the interval between quarterly assessments calculated?

The federal requirement at CFR 483.20 (c) specifies that Quarterly Review assessments must be conducted "not less frequently than once every three months". Timing edits in the MDS standard system count 92-day intervals, because there are never more than 92 days in any consecutive three-month intervals. These 92 days are measured from the date at MDS Item R2b of one assessment to the date at Item R2b of the next. In other words, there can be no more than 92 days between the dates recorded at MDS Item R2b of the last to

the next clinical assessment. This information can be found on CMS ' MDS web site, in the MDS data system specifications:

1. Go to: www.hcfa.gov/medicaid/mds20/mdssoftw.htm.
2. Click on: "Version 1.10 Files Available for Downloading".
3. Click on to download the file: mds110.exe
4. Click on the download mds110.exe file to extract the document spdoc110.pdf (this is a document providing general data specifications information).
5. Review the "Record Timing" timing topic in spdoc110.pdf

CMS has also published a clarification specifying the 92-day interval in our State Operations Manual.

QUESTION 3 - 13: If an assessment shows that the beneficiary's RUG-III group has changed, should the assessment be coded as a Significant Change in Status Assessment (SCSA)?

Not necessarily. A SCSA may be coded as the Reason for Assessment ONLY when a resident has experienced a significant change in condition. A change in a RUG-III group does not by itself constitute a significant change in condition. Conversely, a significant change in condition may or may not cause a change in a RUG-III group. There is no direct relationship between the two. For information on assessing for significant change see: "Guidelines for Determining Significant Change in Resident Status", beginning on page 2-8 in the CMS' Long Term Care Resident Assessment Instrument User's Manual, Version 2.0 published October 1995.

QUESTION 3 - 14: A Medicare assessment was done on day 57 of the stay for a Part A beneficiary. This was the beneficiary's first stay in the facility. The beneficiary's Part A stay ended on day 67. The resident was not discharged from the facility. Is the OBRA quarterly assessment due 92 days from the completion date of the initial admission assessment? Or is it due 92 days from the completion of the Medicare 60-day assessment?

The Medicare assessment schedule does not affect the OBRA assessment schedule. In the above scenario, the next scheduled OBRA assessment is a Quarterly assessment, and it must be completed no later than 92 days from the date recorded at Item R2b of the last OBRA assessment, which was the initial admission assessment.

To minimize assessment burden, facilities may complete one assessment to satisfy both a payment and an OBRA requirement, provided that the assessment meets the criteria specified under both the payment and the clinical rules. The Medicare 60-day assessment can also be coded as the OBRA quarterly

assessment, provided that

- the care plan is reviewed, and updated if appropriate, in accordance with clinical requirements; and
- the assessment include both the items required for the quarterly MDS, and all portions specified for the full, PPS assessment, including Section S. Note that the full assessment contains all items in any of CMS' standard quarterly assessments.

When a quarterly assessment is completed early, the facility may need to adjust the schedule for future assessments in order to ensure that there is not more than 92 days between any two OBRA assessments. The following date requirements must be adhered to when scheduling OBRA required assessments:

- No more than 92 days between ANY two OBRA assessments. This is measured from the completion date recorded at MDS Item R2b on the last OBRA assessment to the completion date at R2b of the current OBRA assessment; AND
- No more than 366 days between any two comprehensive OBRA assessments, (i.e., Initial Admission, Annual, Significant Change, or Significant Correction of Prior Full assessment). The 366 days is measured from the completion date recorded at MDS Item VB2 on the last comprehensive assessment to the completion date at VB2 of the current comprehensive assessment.

QUESTION 3 - 15: When a resident experiences a significant change, how many days does the facility have to complete a Significant Change in Status assessment (SCSA) for SNF PPS?

The rules governing the SCSA are unchanged by PPS. A Significant Change is Status assessment should be performed as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days after the determination is made that a significant change has occurred. This information is provided on page 2-8 of the RAI User's Manual.

If the SCSA results in a change in the RUG-III group, the new payment rate will be effective on the earlier of the Assessment Reference Date of the SCSA or, if the SCSA replaces a regularly scheduled PPS assessment, the first day of the next SNF PPS payment period.

QUESTION 3 - 16: What are the grace days for a Medicare 14-day assessment (AA8b = 7) that is also an initial admission assessment (A8a=1)?

Any time an assessment is completed to satisfy requirements for both a Medicare and a clinical assessment; the assessment must meet the criteria specified under both the payment and the clinical rules. Under Medicare PPS rules, the allowable Assessment Reference Dates for the Medicare 14-day assessment are days 11 through 14, with up to 5 grace days, which could extend the Assessment Reference Dates from day 15 to day 19. The timing rules for the initial admission assessment do not permit the Assessment Reference Date or the completion date to be later than the 14th day of the stay. Therefore, when these two assessments are combined, no grace days can be used.

QUESTION 3 - 17: A Medicare beneficiary's therapy is discontinued, but the beneficiary remains eligible for Part A services. The Other Medicare Required Assessment (OMRA) is done timely. A few days later, the beneficiary again becomes able to participate in therapy. How does the facility code the next MDS and when would it be done?

Initiation or return to therapy, is not, by itself, a reason to complete a new assessment; however, a significant change in condition may have contributed to the resident commencing therapy. Provided that the resident has not experienced a significant change in status, the facility would continue to perform MDS assessments in accordance with the Medicare schedule. The MDS would be coded as the 5, 14, 30, 60 or 90-day assessments, as appropriate.

Please note that the facility needs to assess the resident using the guidelines provided in the RAI User's Manual beginning on page 2-8 for guidance in determining whether a significant change has occurred.

QUESTION 3 - 18: Do hospitalizations affect the timing of the Medicare PPS assessments?

Yes. As shown in the example below, inpatient hospitalizations restart the SNF PPS assessment schedule.

Example:	
Admitted to SNF:	March 1
Discharged to hospital:	March 4
Returned to SNF:	March 7

Staff should make every effort to complete a 5-day assessment for SNF PPS billing purposes. The assessment reference date may be no later than March 4. Without this assessment, the SNF would have to bill at the default rate from March 1-March 4.

When the beneficiary returns on March 7, the Medicare assessment schedule

starts over with a readmission/return assessment (A8b=5). The assessment reference date must be within 8 days of the return (i.e., within 5 days of the reentry plus 3 grace days).

The schedule for the Medicare 14-day assessment will be determined using the reentry date (March 7) as day 1.

Instructions concerning the impact of hospitalization on the timing of the OBRA Initial Admission assessment appear on page 2-7 of the RAI User's Manual. "If a resident goes to the hospital and returns during the 14 day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. Otherwise the assessment should be reinitiated and completed within 14 days after readmission from the hospital. The portion of the resident's record that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized."

To minimize assessment burden, the facility may combine the Initial Admission assessment with either the Medicare 5-day Reentry assessment, or the Medicare 14-day assessment.

QUESTION 3 - 19: Must RAPS be completed with Medicare assessments?

RAPs are not required for Medicare assessments. RAPs are ONLY required for comprehensive clinical assessments. However, when a Medicare assessment is combined with a comprehensive clinical assessment, the RAPs must be completed in order to meet the requirements of the comprehensive clinical assessment. Comprehensive clinical assessments are identified at MDS Item AA8a, and include only the following four Reasons for Assessment:

Admission (AA8a = 1)
Annual (AA8a = 2)
Significant Change in Status Assessment (AA8A = 3)
Significant Correction of Prior Full (read "full" as "comprehensive") Assessment (AA8a = 4)

QUESTION 3 - 20: What MDS records are required when a resident returns to the facility following a hospital observational stay of less than 24 hours?

For hospital observational stays of less than 24 hours, the resident stays on the previously established clinical and PPS assessment schedule, unless the resident experienced a significant change. If a significant change occurred, the facility should complete a significant change assessment.

The response to this question can also be found in Exhibit 260 in the State Operations Manual: "MDS 2.0 Discharge and Reentry Flowchart", available on the CMS website at:
www.hcfa.gov/pubforms/transmit/2000/transmittals/comm_date_dsc.htm
and cited in the CMS' RAI Version 2.0 Q&A's, March 2001, question 2 – 6, at:
www.hcfa.gov/medicaid/mds20/default.htm.

QUESTION 3 - 21: Can a facility complete the OBRA Quarterly assessment early, in order to combine it with the Medicare 60-day assessment?

Yes. When the first quarterly assessment is completed early, and combined with the Medicare 60-day assessment, future assessment requirements can be satisfied in one the following ways:

- Complete two more quarterly assessments no more than 92 days apart, and an annual assessment no more than 92 days after the third Quarterly. Using this option, the facility completes the annual assessment early, in order to meet the 92-day requirement; OR
- Complete three more quarterly assessments within 92 days of each other, and an annual assessment within 366 days of the last comprehensive assessment. Using this option, the facility completes an extra quarterly assessment, in order to meet the 92-day requirement.

QUESTION 3 - 22: If we complete one assessment to satisfy requirements for both an OBRA Quarterly and a Medicare PPS assessment, which assessment form should we use? The Quarterly assessment form? Or the full assessment form?

When a facility uses one assessment to satisfy requirements for both an OBRA and a Medicare PPS assessment, the facility must comply with both sets of rules. When a Quarterly and a PPS assessment are done in combination, use the full assessment form, because it contains all the portions of the MDS required for payment, and it also contains all of the Items on any of CMS' standard Quarterly assessment forms. Also be sure to review the care plan, and update it if appropriate, to satisfy the care plan component of the Quarterly assessment. In this scenario, use code "5" (Quarterly) at MDS Item AA8a, and also code the appropriate Medicare Reason for Assessment at Item AA8b.

In a separate but related scenario, a facility may also combine a comprehensive OBRA assessment with a Medicare PPS assessment. In that case, the full assessment, plus the RAPs and care plan component, must all be completed. When the comprehensive assessment is an initial admission assessment, the

Background (Face Sheet) information (Sections AA through AD) must also be completed.

QUESTION 3 - 23: If a Significant Change in Status Assessment (SCSA) for a Medicare Part A covered stay is done outside a Medicare assessment window and changes the RUG-III group, is that SCSA used in billing?

Yes. If an SCSA is required and it results in a different RUG III group, a bill must be sent to Medicare. The SCSA is considered an off-cycle Medicare assessment. The SNF should bill the new RUG-III group effective on the earlier of the assessment reference date (ARD) of the SCSA, or, if the SCSA is also a replacement for a regularly scheduled PPS assessment, the first day of that PPS payment period.

The payment will stay in effect until the beginning of the next payment period, or the ARD of the next off-cycle assessment (i.e., another SCSA, an Other Medicare Required Assessment (OMRA) or a Significant Correction of Prior Assessment (SCPA)), whichever is earlier.

QUESTION 3 - 24: How should Item AA8b be coded for an Other Medicare Required Assessment (OMRA)…

A. When the Assessment Reference Date (ARD) is within the assessment window of a scheduled Medicare assessment?

When the ARD of the OMRA falls within the assessment window of a scheduled PPS assessment, use code "8" at MDS Item AA8b. The HIPPS assessment indicator code will alert the FI that this also serves as a scheduled PPS assessment.

B. When it is NOT within an assessment window of a scheduled Medicare required assessment?

Also code AA8b "8" (OMRA) when the ARD of the OMRA does NOT fall within the assessment window of a scheduled PPS assessment.

C. When it is also a Significant Change in Status Assessment (SCSA)?
When an OMRA is also a SCSA, use code "3" (Significant Change) at MDS Item AA8a, and code "8" (OMRA) at MDS Item AA8b.

D. When it is NOT a SCSA?
When the OMRA is NOT also a SCSA, use the appropriate code at MDS Item AA8a (depending on whether this PPS assessment is combined with any other type of clinical assessment), and code "8" (OMRA) at MDS Item AA8b.

For more information on billing instructions, refer to Program Memoranda A0047 and A0156, available on CMS' website at: www.hcfa.gov/medicare/snfpps.htm

QUESTION 3 - 25: If an Other Medicare Required Assessment (OMRA) is also a significant change in Status Assessment (SCSA), do you use the OMRA time frames, (e.g., 8-10 days after therapy is discontinued), or the SCSA time frame, (e.g., 14 days from the date staff identifies the significant change)?

Any time an assessment is completed to meet requirements for both a Medicare and a clinical assessment; both sets of rules must be followed. The Medicare rules require that an OMRA assessment be performed for residents who continue to require skilled services using an Assessment Reference Date (at Item A3a), that falls on the 8th, 9th or 10th day after all therapies have been discontinued. The clinical rules require that a SCSA be completed at MDS Item VB2 within 14 days of identifying the change. A comprehensive assessment (including RAPs and Care Planning); that uses an assessment reference date of day 8, 9 or 10; and that is competed within 14 days of the date the determination was made that as Significant Change occurred; satisfies both the Medicare and the OBRA timing requirements.

QUESTION 3 - 26: Does the facility need to complete and transmit a discharge tracking form if the resident's bed is being held?

The requirements for completion of a Discharge Tracking form are not associated with bedhold status. A Discharge Tracking form is required whenever a resident is discharged, regardless of bedhold status. If the bed is being held, it logically follows that return is anticipated, and Item AA8a on the Discharge Tracking form is coded "7" (return anticipated).

QUESTION 3 - 27: Is it necessary that a resident have a bedhold in order to code Item AA8a on the Discharge Tracking form "7" (return anticipated)?

No.

QUESTION 3 - 28: Should Item AA8a (Reason for Assessment) be coded "8" (discharged prior to completing initial assessment) even when the resident is not returning, e.g., the resident died or was transferred to another facility)?

Yes. Even when you know that the resident is not returning, if the initial Admission assessment, (MDS Item AA8a = 1), has not been completed, a Discharge Tracking form is required. In this case, Item AA8a should be coded "8" (discharged prior to completing initial assessment). This is true regardless of the reason for the discharge. It is also true regardless of whether the Medicare 5-day assessment was completed. Additional guidance for coding Item AA8a in the event of discharge and reentry can be found in Exhibit 260 in the State Operations Manual: "MDS 2.0 Discharge and Reentry Flowchart". This flowchart is available on the CMS website at:
www.hcfa.gov/pubforms/transmit/2000/transmittals/comm_date_dsc.htm
and cited in the CMS RAI Version 2.0 Q&A's, March 2001, question 2 – 6, at:
www.hcfa.gov/medicaid/mds20/default.htm

Questions on Items in MDS Section AC

QUESTION 3 - 29: Who is responsible for completing Section AC1, Customary Routine?

Facilities have flexibility in determining who should participate in the assessment process as long as the MDS 2.0 is accurately conducted. A facility may assign the Customary Routine section to one person or to several members of the interdisciplinary team. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. All staff who completed any part of Sections AA - AC must sign their names and identify the sections they have completed in Section AD. Refer to the information under "Participants in the Assessment Process" on page 2-16 of the RAI User's Manual.

QUESTION 3 - 30: What is the purpose of obtaining the information needed to complete Section AC1 Customary Routine?

Engaging the resident and or the family member in a discussion about the resident's routines in the year prior to the date of entry is an excellent means of obtaining important information and starting the therapeutic relationship between facility clinicians and the resident and family. Information about the resident's prior routines in areas such as bathing, dietary preferences, and usual social activities or hobbies can be used by the facility staff to develop a care plan that is specific to that resident's needs and preferences. Through the completion of Section AC, the nursing home staff begins the assessment of areas such as speech patterns, hearing, vision, cognition, decision-making, and others.

Questions on Items in MDS Section B

QUESTION 3 - 31: Regarding MDS Item B2a, (Short-term memory – OK), if a resident independently arrives to all scheduled meals on time, is this enough evidence to conclude that the resident's short-term memory is OK?

No. Many persons with memory problems can learn to function successfully in a structured, routine environment such as a nursing facility. Observing resident function in multiple daily activities is only one aspect of evaluating short-term memory function, but is an important component for assessing MDS Item B4, Cognitive Skills for Daily Decision Making. MDS Item B2a focuses on a specific aspect of cognitive function called "short-term memory" and directs you to determine if the resident seems or appears to recall (what was learned or known) after 5 minutes. Nursing facility staff are very familiar with residents who may function well in daily activities but cannot remember what staff told them or what happened 5 minutes ago. For example, a resident may remember to come to lunch but may not remember what he ate. As described in the RAI User's Manual (pp. 3-41 to 3-43), use a direct approach to test short-term memory during a conversation with the resident. The following test is excerpted from the User's Manual, page 3-43.

> Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them to you (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1."

QUESTION 3 - 32: If a resident's short-term memory function fluctuated throughout the 7-day observation period, how should Item B2a be coded?

The intent of this Item is to identify the resident's assets and strengths so that the health care team can draw upon these strengths in developing a care plan. Code the resident at his/her highest level of functioning. During the 7-day assessment period, give the resident the simple short-term memory test described in the RAI User's Manual, page 3-43 (below). If the resident's short-term memory fluctuates, staff may re-test the resident, and in order to give the resident the benefit of the doubt, use the best test as a basis for coding Item B2a.

Ask the resident to remember three items (e.g., book, watch, and table) for a few minutes. After you have stated all three items, ask the resident to repeat them to you (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1."

Questions on Items in MDS Section D

QUESTION 3 - 33: For the purpose of coding MDS Item D1 (Vision Patterns), is it necessary to use an eye chart to test the resident's vision?

It is not necessary to use an eye chart to test a resident's vision. However if an eye chart is used, the results of the eye exam may be used in coding Item D1.

The recommendation in the RAI User's Manual (pages 3-55 and 3-56) is to ask the resident to read material that is regular size newsprint. If the resident can not see this, then the assessor moves on to large print text. It is difficult to identify and assess residents who cannot read in English, or to identify and assess residents who may not be able to read in their primary language. Such residents may be asked to identify numbers, shapes or symbols in the two sizes (equivalent to regular and large print).

For residents who do not have the ability to see small objects and who are unable to participate in the eye testing described above, the assessor needs to conduct his or her own observation during the assessment process. Information may also be obtained by consulting with other staff who may be familiar with the resident's visual acuity.

Questions on Items in MDS Section E

QUESTION 3 - 34: It is difficult to track all the signs and symptoms at Items E1a-p, (Indicators of Depression, Anxiety, Sad Mood) over the 30 day observation period. Do you have suggestions for monitoring them?

The keys to obtaining, tracking and recording accurate information in Section E are 1) interviews with and observations of residents, and 2) communication

between licensed and non-licensed staff and other caregivers (See RAI User's Manual p.3-58).

- Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers is crucial for resident monitoring and care giving.
- The Mood Items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether it occurred at all. If not, use code "0". If the resident exhibited the behavior almost daily (6, 7 days/week) or multiple times daily, code "2". If codes "0" or "2" do not reflect the resident's status, but the behavior at least once, use code "1".
- Educate all caregivers (including direct care staff) about the residents' status in this area, and how to observe mood and behavior patterns that are captured in Section E of the MDS. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated in nursing homes. Part of the reason may be that staff tend to perceive them as the residents' "normal" or "usual" behaviors.
- Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. It should be used in planning and individualizing appropriate care and treatment. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor, on an on-going basis, the resident's status and response to treatment. It is up to the facility to determine the form and format of such documentation.

QUESTION 3 - 35: In my facility the social worker completes Section E. The nurses have noticed that signs of depression and behavioral problems are sometimes coded as "Not present", even when they have observed them occurring. The social worker said that if there is no documentation that the behavior occurred, she must code it as "not present". Does this mean that staff must document occurrences of behavior that is captured in Section E?

Any person completing this, or any other MDS section, is required to follow the Item-by-Item guidelines in the RAI User's manual that specify sources of information necessary for accurate coding. For this section, the process of information gathering should include direct observation of the resident; communication with the resident's direct caregivers across all shifts; review of relevant information in the resident's clinical record; and if possible, consultation with family members who have direct knowledge of the resident's behavior in the

observation period. Refer to the RAI User's Manual, page 3-58 through 3-68. If the person completing the MDS did not personally observe the behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the MDS form. In addition, the resident's clinical record should support their status as reported on the MDS.

QUESTION 3 - 36: Regarding MDS Section E (Mood and Behavior Patterns), when a resident has exhibited several indicators of depression or anxiety for 2 years (i.e., daily negative statements, persistent anger with others, insomnia) do we still need to record these behaviors on the MDS assessment? The resident's psychiatrist tells us these signs are consistent with her disease and there is nothing more we can do to minimize them.

Documenting chronic mood and behavioral symptoms is no less important than documenting chronic physical problems such as chest pain, shortness of breath or recurrent lung aspirations. The MDS provides a perspective of how the resident functions now, and over the entire course of the stay. All active signs of mood or behavioral problems specified in Section E must be accurately documented on the MDS, even if all appropriate pharmacological and non-pharmacological interventions have been tried and this is the best level of function that can be achieved for this resident. Symptoms that cannot be lessened are no less important when considering the resident's overall health status. In fact, such symptoms may impact other health issues.

QUESTION 3 - 37: My staff is concerned that they are "labeling" the resident as being "depressed" or "anxious" when coding indicators at Section E of the MDS. Is this so?

Coding the presence of indicators in Section E does not automatically mean that the resident has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in Section E. They simply record the presence or absence of specific indicators and behaviors. It's important that facility staff recognizes these clinical indicators, and consider them when developing the resident's care plan. When indicators are present, Section E Items serve as triggers for the interdisciplinary team to consider the appropriate RAP(s). Upon review of the RAP guidelines, the interdisciplinary team makes decisions about the need for further evaluations, referrals, and diagnoses.

Questions on Items in MDS Section F

QUESTION 3 - 38: How do you determine whether a resident is "at ease" for the purpose of coding MDS Items F1b (At Ease Doing Planned or Structured Activities), and F1c (At Ease Doing Self-Initiated Activities)?

To code these Items, assess whether the resident is *involved*, and *takes initiative* in participating in social and recreational programs, including solitary pursuits.

Item F1b, "At Ease Doing Planned or Structured Activities", should be checked for a resident who is comfortable with, or doesn't feel restricted by planned or structured activities, for example, a resident who pursues activity programs, seems content to be involved, and takes initiative in participating. This Item should be left blank for a resident who is not at ease with planned activities, for example, a resident who is unable to sit still during activities, or who is disruptive, attempts to leave, or refuses to attend.

Item F1c, "At Ease Doing Self-Initiated Activities", should be checked for

residents who are able to occupy at least some of their leisure time with meaningful, self-directed activities. Such residents find things to do to occupy themselves, like reading a book, organizing their belongings, visiting other residents, writing letters or making phone calls. This Item should be left blank for residents who are not at ease doing self-initiated activities. Such residents may spend most of their time alone and unoccupied, or are dependent on others to occupy their leisure time. For these residents, there is no element of self-direction or self-initiation in activity involvement.

Coding instructions for Items F1b and c appear on pages 3-68 to 69 of the RAI User's Manual.

QUESTION 3 - 39: Regarding MDS Item F1b (At Ease Doing Planned or Structured Activities), how is a cognitively impaired resident assessed for being "at ease"?

A cognitively impaired resident participating in organized social or recreational activities may show signs of being "at ease" with the activity by smiling; making eye contact with the activity leader; actively participating in the activity (singing, dancing, tapping, clapping); and if not actively participating, then the resident may be sitting or standing quietly during the activity. A resident who is not "at ease" during an activity might cry or call out during the activity; repeatedly try to get up to leave the activity and not respond to gentle cueing to return to participation in the activity; shout or strike out at staff or other residents.

Questions on Items in MDS Section G

QUESTION 3 - 40: Should a therapist complete Section G (Physical Functioning and Structural Problems)?

Facilities have flexibility in determining who should participate in the assessment process as long as the MDS 2.0 is accurately conducted. The RAI instructions do not specify which discipline must complete any section of the MDS. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. Facilities are responsible for assigning a qualified person to complete a specific section or sections of the MDS 2.0 Assessment. Refer to the information under "Participants in the Assessment Process" on page 2-16 of the RAI User's Manual.

QUESTION 3 - 41: We have trouble collecting data to accurately code ADLs and differentiating between levels of assistance. Do you have any suggestions to simplify this data collection process?

The key to ADL coding is the concept of three events. First the assessor determines whether the resident has been totally dependent. For a resident to have a code of totally dependent for ADLs, each time the activity occurred the resident had to be totally dependent (did not contribute to the activity at all), there were no exceptions. As soon as the resident did some part of the activity, the resident was not totally dependent. For all other categories, the clinician is reviewing for the most dependent activity that occurred at least 3 times in the last 7 days. Knowing the total number of times the activity occurred is not necessary for scoring accuracy. Knowing whether the activity occurred 3 or more times in the last 7 days is key to ADL coding accuracy.

The ADL coding was created to reflect real situations in nursing homes, where small variations in performance are common. For example, in scoring a resident as independent in ADL self-performance, there can be 1 or 2 exceptions. As soon as there are 3 exceptions, the resident is not independent, and you need to consider another code. Staff who are new to conducting MDS assessments need to become familiar with the coding structure, and how exceptions are handled. Codes of 0, 1, 2, 3, (Independent, Supervision, Limited Assistance, and Extensive Assistance) have been designed to allow one or two exceptions for the provision of assistance from the staff helper.

Information must be sought from multiple sources. These sources include the following: interviews or discussion with resident and direct care staff on all three shifts, including weekends; review of documentation used for staff communication across the three shifts; the assessor's own observation of the resident performing certain tasks (if possible). If therapies are involved with the resident, their input should be included either by way of an interview with the therapist or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit.

When discussing self-performance with direct care staff, residents or therapists, it is important to ask questions related to all aspects of the ADL activity. For example, when discussing bed mobility with a CNA, be sure to ask how the resident moves to and from a lying position, how the resident turns from side to side, and how the resident accomplishes positioning while in bed. A resident may be independent in one aspect of Bed Mobility, and require extensive assistance in another aspect. Also key in on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.

QUESTION 3 - 42: I was advised that all nursing home residents should be coded as "supervision" under self-performance in eating at Item G1hA, because there should always be someone supervising the residents as they eat. Is this correct?

No. General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1hA is coded as "0" (Independent). If the individual resident needed oversight, encouragement, or cuing during the last 7 days, the Item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cuing and also received more help, such as physical assistance provided one or two times during the 7 day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in "feeding" or "eating" groups and who are individually supervised during the meal, would be coded as "1" (Supervision), for Self Performance in Eating.

QUESTION 3 - 43: How can we differentiate between guided maneuvering and weight-bearing assistance when coding self-performance in eating, at MDS Item G1hA?

The key to the differentiation is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping them to eat, (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident can lift

the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering.

QUESTION 3 - 44: In our facility the rehabilitation notes are often used to code the Items at G4 (Functional Limitation in Range of Motion). However, for the long-stay residents, these evaluations are not always in the current chart.

In developing the User's Manual, we recognized that this was likely to happen. If no assessment has been conducted and documented by a therapist within the last seven days, then a clinical professional (e.g., nurse) may assess this area following the guidance in the RAI User's Manual. Detailed instructions on how to perform the functional range of motion tests and voluntary movement tests begin on page 3-95 of the Manual. In this Item we are moving from performance issues to structural issues. We are not asking how an activity is carried out; we are determining the structural ability of the limbs to move.

QUESTION 3 - 45: There is a statement on page 3-96 of the RAI User's Manual that needs to be clarified. It reads, " at Item G4 code the appropriate response of the resident's active (or assisted passive) ROM function during the past 7 days." It seems to me that passive movement is not assisted; rather it is performed for the resident. On the other hand, active movement can be assisted to complete the ROM. I think the term "assisted" should be left out of the statement.

The term "assisted passive" should read "assistive/passive" as stated at the top of the page 3-96. Read "/ " as "or".

QUESTION 3 - 46: If a gait belt is used when transferring a resident, should Item G6e (transfer aid) be checked?

If the gait belt is used during transfer of the resident, then Item G6e "transfer aid" should be checked.

Questions on Items in MDS Section H

QUESTION 3 - 47: It is difficult to make the correct selection on the continence scale when coding for bowel continence (H1a) and bladder continence (H1b). What is the best way to ensure accurate coding?

According to the RAI Users' Manual (pg. 3 – 106) assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct care staff across all shifts.

The keys to obtaining, tracking and recording accurate information in Section H are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers (Refer to the RAI User's Manual, pages 3-105 through 3-110).

- Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area. Staff who work most closely with residents will know how often they are dry or wet.
- Focus your assessment over the last 14 days. When getting information about continence from CNA's start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the resident is always dry, code "0", (Continent). If the resident is always wet, and has no control, code "4", (Incontinent). If incontinence occurs only once a week, or less, code "1", (Usually continent). The difference between code "2" (Occasionally incontinent), and code "3" (Frequently incontinent) is that for code "3", the resident is incontinent at least daily or multiple times a day.

QUESTION 3 - 48: If a fecal impaction located in the rectum was noted by x-ray, but not by digital exam, should it still be coded on the MDS at Item H2d? The definition in the RAI User's Manual instructs the assessor to code a fecal impaction if it is seen on a x-ray in the sigmoid colon or higher.

The definition in the RAI User's Manual discusses the usual case. It does not provide for excluding from MDS coding fecal impaction detected elsewhere. Fecal impaction should always be coded whether it is detected by physical exam, x-ray or any other method.

QUESTION 3 - 49: If the resident's incontinence briefs, pads, or linens are changed every two hours or when they are wet, should we check "scheduled toileting plan" (MDS Item H3a in the "Appliances and Programs" section)?

No. There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as

appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void. Refer to the RAI User's Manual Version 2.0, p. 3-108.

QUESTION 3 - 50: A Certified Nurse Assistant (CNA) walks the resident to the bathroom according to a scheduled program (upon arising, after each meal, and at bedtime) five times per day. However, between these times the resident is often incontinent of bladder. Should we still check Item H3a, "scheduled toileting plan"?

Yes. If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident is on a scheduled toileting program and is still incontinent of bladder, record the resident's level of bladder continence in Item H1b. In view of the resident's breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI; mobility problem; etc.), and treating the underlying cause. Also determine whether there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly.

Questions on Items in MDS Section K

QUESTION 3 - 51: A resident is identified as having a swallowing problem that has been handled with successful care plan interventions (thickened liquids, speech therapy). At the time of an MDS assessment, the resident does not exhibit the signs of dysphagia, therefore the assessor leaves K1b blank. Isn't the resident still at risk for complications or injury due to the dysphagia?

This is an example of a problem identified by the interdisciplinary team that has not "triggered" a RAP. A plan of care must be developed to address the problem and prevent complications. The problem exists and it is obvious from this example that the facility has developed an appropriate plan of care.

QUESTION 3 - 52: Regarding MDS Item K3a, we often have difficulty determining if there has been a 5% or more weight loss in the last 30 days,

or a 10% or more weight loss in the last 180 days. Our dietary documentation refers to Ideal Body Weight (IBW) and not to weights obtained in prior time periods.

Good clinical practice dictates that facilities monitor and record height and weight as part of the monitoring of a resident's health status. To code Item K3 (Weight change) accurately, the facility must obtain a resident's weight at the 30 day and 180 daytime periods.

QUESTION 3 - 53: How can the percentages be calculated to accurately code Item K3a (Weight Loss)?

The first step in calculating percent weight loss is to obtain the weights for the 30 day and 180 day time periods from the resident's clinical record. The calculation is as follows:

a. Start with the resident's weight from 30 days ago and multiply it by the proportion (0.05). If the resident has gained or lost more than this 5%, code a "1" for Yes at Item K3a.

b. Start with the resident's weight from 180 days ago and multiply it by the proportion (0.10). If the resident has gained or lost more than this 10%, code a "1" for Yes at Item K3a.

There are also charts available that make it easy for staff to calculate the percent of weight lost or gained.

QUESTION 3 - 54: Should Item K5e, (Therapeutic diet) be checked if a resident is on a "no added salt" (NAS) diet?

Yes. A no added salt diet ordered by the physician is considered a therapeutic diet.

QUESTION 3 - 55: Is there a requirement as to the amount or frequency of nutritional supplements in order to include them at Item K5f (Dietary Supplement) as a nutritional approach?

There is no requirement specifying the amount or frequency of nutritional supplements. The RAI User's Manual p. 3-130 states "Any type of dietary supplement provided between meals." This Item does not include supplements provided at meal times.

Questions on Items in MDS Section M

QUESTION 3 - 56: When coding skin condition Items in Section M, are assessors required to perform a physical assessment of skin, or can the information be obtained through clinical record review?

In general, MDS coding instructions call for the use of multiple sources of information to enhance coding accuracy. Unless the RAI User's Manual specifies to do so, assessors should not rely on the clinical record as the sole source of information about the presence or absence of any condition.

A skin examination is necessary for problem identification and accurate coding of Section M. The RAI User's Manual, page 3-135, states "Examine the resident…Without a full body check, an ulcer can be missed." This examination must be performed by a clinician knowledgeable in the process of evaluating skin integrity. It does not necessarily have to be performed by the assessor completing the MDS form. Some facilities have found that it is more convenient for staff, as well as for residents, when the skin assessment is conducted during bathing or dressing activities.

QUESTION 3 - 57: Should a blister in the incontinence brief area (e.g., irritation causing a blister on the front of the torso) be recorded at Item M1 (Ulcer due to any cause) as a Stage 2 Ulcer? Should it be coded as a pressure ulcer for Item M2a?

At Item M1, code ulcers that correspond to the definitions provided on the form and in the RAI User's Manual on pages 3-134 and 3-135, regardless of the cause of the ulcer. A Stage 2 Ulcer is defined as "A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater". In this case, a blister in the incontinence brief area should be considered as a Stage 2 ulcer at Item M1.

In order to code Item M2a (Pressure ulcer) the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, the blister was found in the area of the incontinence brief waist or leg band, pressure from the band is a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer but would be considered a rash, and Item M4d (Rashes) would be checked. Refer to the RAI

User's Manual, p. 3-137.

For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

QUESTION 3 - 58: After a pressure ulcer Stage II - IV has been debrided, should assessors stop coding it in Section M1 (Ulcers)?

No. Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists, and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate at Item M5, (Skin Treatments).

QUESTION 3 - 59: Should the Pressure Ulcer Scales for Healing (PUSH), or reverse staging, be used when coding the appearance of an ulcer at MDS Item M1?

Continue to use reverse staging for version 2.0 of the MDS, as per the Item coding instructions in the RAI User's Manual, beginning on page 3-134. CMS is considering incorporating the PUSH scale in a future iteration of the MDS.

QUESTION 3 - 60: One of our residents has 5 open wounds as a result of frostbite and not pressure or venous stasis. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: 4 of them are consistent with Stage 2 ulcer staging, and 1 of them appears to be at Stage 3. How should these be recorded in Section M, Skin Conditions?

This is an interesting case where the resident does not fit the type of skin problems commonly seen in nursing facilities. Assuming that the resident in this scenario has no stasis or pressure ulcers, code the resident's condition as follows:

- Item M1, Ulcers (due to any cause). Because this Item does not require that the cause of the ulcer be known:
  - M1a. Stage 1, code "0" (no ulcers at stage 1)
  - M1b. Stage 2, code "4" (4 ulcers at stage 2)
  - M1c. Stage 3, code "1" (1 ulcer at stage 3)
  - M1d. Stage 4, code "0" (no ulcers at stage 4)
- Item M2, Type of ulcer:

M2a. Pressure ulcer, code "0" (highest stage ulcer is not a pressure ulcer)
M2b. Stasis ulcer, code "0" (highest stage ulcer is not a stasis ulcer)

Be sure to examine the resident and code Section M for other skin conditions, including those of the feet, as well as treatments being provided. Also enter the appropriate ICD-9 code for "frostbite" as specified in the 991.0 - 991.3 ICD-9 series in Section I3, Other diagnoses.

QUESTION 3 - 61: If a resident has redness and excoriation over her buttocks related to multiple daily incontinent episodes of diarrhea, should the redness be coded in Item M1 (Ulcers due to any cause), as a Stage 1 ulcer (M1a = 1) and as a rash (M4d = checked)? It does not seem that pressure is the cause of this redness.

If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1a=1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. If the resident has compromised mobility, pressure is very likely and Item M1a should be coded as "1". If this is a situation where the redness is from pressure and a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code, M2a (pressure ulcer) and M4d (rashes). If the resident's mobility status is not impaired and the redness is not likely due to pressure, code M4d (rash). In this scenario, the incontinent episodes of diarrhea should be coded at Item H1a (Bowel Continence). This should also be coded at H2c (Diarrhea), if appropriate.

QUESTION 3 - 62: Should all skin and foot problems that were coded on a prior assessment at Items M4 (Other skin problems) and M6 (Foot problems and care), also be recorded on the current MDS assessment, even if they are healing?

Yes. Even if they were already recorded on a prior MDS assessment and are now healing, all problems and lesions present during the current observation period should be documented on the MDS. These Items refer to the objective presence of problems or lesions, not the status of such. Refer to the RAI User's Manual, p. 3-137 to 140.

QUESTION 3 - 63: Is it necessary to have supporting clinical record documentation of treatments listed in Item M5 (Skin treatments, e.g., turning and repositioning program; application of ointments) and M6 (Foot

problems and care, e.g., trimming of nails/calluses; and application of dressings)?

Yes. It's a matter of good clinical practice to have such documentation. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility.

In answer to this inquiry, and in general concerning documentation that supports clinical practice (including resident assessment), refer to the CMS March 2001 publication of RAI Version 2.0 Q & A's (Question 2-2, p. 3), The following is excerpted from that document:

"… completion of the MDS does not obviate the facility's responsibility to document a more detailed assessment of particular issues of relevance to the resident (e.g., as might be discovered through the RAPs, or by assessing areas not included or covered in sufficient depth on the MDS). Facilities are also required to document the resident's care and response to care during the course of the stay and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment or quarterly review and related care issues. Bear in mind that government requirements are not the only reason for clinical documentation. The MDS system has codified some documentation requirements into a standard format. In addition, clinical documentation that contributes to the identification and communication of residents' problems, needs and strengths, that monitors their condition on an on-going basis, and that records the treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals."

It is up to the facility to determine the form and format of such documentation.

QUESTION 3 - 64: Should the use of a chair pad or mattress that has been defined by the manufacturer as "pressure relieving" be checked in Item M5a (Pressure relieving device for chair) or M5b (Pressure relieving device for bed)?

Yes. If the pressure-relieving device was used in the observation period, check M5a if it was for a chair, and M5b if it was for a bed. However, do not check either Item if the device was an egg crate cushion or mattress. These are specifically excluded from coding, as specified in the RAI User's Manual on page 3-139.

QUESTION 3 - 65: Must dressings be changed daily in order to be recorded at Item M5e (Ulcer care), M5f (Surgical wound care), M5g (Application of dressings [other than to feet]), or M6f (Application of dressings [to the

foot])?

No. The RAI User's Manual pp. 3-138 to 3-140 provides definitions for these MDS Items and instructs the assessor to "check all that apply" during the 7-day observation period. Thus, if any dressing meeting the MDS definitions provided for Items M5e, M5f, M5g or M6f was applied even once during the 7-day period, the assessor would check the appropriate MDS Item.

Questions on Items in MDS Section N

QUESTION 3 - 66: Please expand on the coding instructions on page 3-141 of the RAI User's Manual for Item N1 (Time Awake), by offering examples and discussing appropriate methods of information gathering.

Item N1, "Time Awake", identifies periods of the day when a resident is typically awake all or most of the time. The time periods, Morning (Item N1a), Afternoon (Item N1b), and Evening (Item N1c), are defined for each individual resident based on when they typically wake up in the morning and are asleep at night. Morning is generally defined as between 7:00 am and noon. But for a resident who typically wakes up earlier, (e.g., at 6:00 am), then the morning period for that resident is 6:00 am until noon. Afternoon is always defined as between noon and 5:00 pm. Evening is generally defined as between 5:00 pm and 10:00 pm. But for a resident who is typically asleep earlier, (e.g., at 9:00 pm), then the evening time period for that resident is between 5:00 pm and 9:00 pm. When coding Items N1a, b and c, check each time period, as defined for that resident, during which he or she did not nap for more than one hour.

Some examples of coding Item N1 are as follows:

- A resident wakes up every morning at 7:00 am. He typically eats breakfast, has a shower, gets dressed and goes back to bed for a late morning nap from 10:00 am until 11:30 am. Item N1a (Morning) should NOT be checked, since this resident typically naps for more than 1 hour during the morning.

- A resident typically wakes up at 6:00 am. She is busy with therapy and activities most of the day, and does not take naps. She goes to bed by 7:00 pm every evening. Items N1a (Morning), N1b (Afternoon) and N1c (Evening) should all be checked, since this resident does not take naps.

- A resident who is bedfast and has end-stage Alzheimer's disease wakes up at 6:00 am daily. She typically dozes off throughout day, napping for more than 1 hour before noon, and again from 3:30 pm to 5:30 pm every afternoon. She is typically awake from 5:30 until 9:00 pm. After that, she's asleep for the night. Items N1a (Morning) and N1b (Afternoon) should NOT be checked, since this resident naps for more than one hour during each of these periods. Item N1c (Evening) should be checked as time awake. Although this resident sleeps until 5:30 pm, that is only a 30-minute naptime in the Evening period.

In general, accurate coding of MDS Items relies on the use of the Item coding instructions in the RAI User's Manual, and the use of appropriate information gathering techniques. Coding Items N1a, b, and c, based on only the assessor's personal knowledge of a resident's sleep and awake patterns might not result in an accurate response. Documentation review is important. However, since we would generally not expect facility staff to maintain flowcharts for information such as sleep and awake times, documentation is not always available. Therefore, it's important to observe the resident across all shifts. In addition, the same individual staff member is generally not on duty and available to observe a resident across a 24 hour period. That's why it's important to supplement observation with interviews of the resident, their family members, other staff across shifts, and in particular, the CNAs who care for that resident.

Questions on Items in MDS Section O

QUESTION 3 - 67: The RAI User's Manual, as well as previously released Q & A's are clear that, for the purposes of MDS coding, vitamins should be counted when coding Section O (Medications). What if a resident receives a dietary supplement between meals that includes a vitamin as one of its ingredients? Should that be coded as a dietary supplement, or as a medication?

If a dietary supplement given to a resident between meals has a vitamin as one of its ingredients, code it as a dietary supplement, *not* as a medication.

Coding Examples:
If a resident receives a daily Vitamin C capsule, add it to the medication count in number of medications (O1).

If a resident receives a dietary supplement between meals and the label contents specify that Vitamin C (or any other vitamin, etc) is one of the ingredients, code

(K5a = check) for dietary supplement between meals.

QUESTION 3 - 68: If an herbal remedy or other natural/alternative product contains a vitamin as one of its ingredients, should it be counted as a medication when coding Section O?

No. Herbal remedies or other natural/alternative products should not be coded as a medication.

QUESTION 3 - 69: Are PPD tests for tuberculosis, or vaccines (e.g., influenza, and pneumovax) to be coded under injections at MDS Item O3, when given in the observation period?

For MDS Item 03, the RAI Users' Manual (p.146) specifies to record the number of DAYS during the past 7 days the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular, or intradermal injection"...including "biologicals", so one can track for localized or systemic reactions. Assuming these are the only injections given in the observation period - if the resident received one of these injections on one day, and the other on a different day, code "2" for the number of days the resident received injections. If both injections were given on the same day, code "1". Also include these when coding Item O1 (Number of medications).

QUESTION 3 - 70: Question numbers 97 and 98 in the CMS 1996 Q & A publication state to code a medication in Item O4 (Days Received the Following Medication) for its classification, and not its use. If a medication has more than one classification, how should it be coded? For example, phenobarbitol is considered an anticonvulsant and a barbiturate. It is listed in Appendix E in the RAI User's Manual (p. E-1) under antianxiety drug. If Phenobarbital was given daily for control of seizure activity, should the number of days the resident received it be recorded at MDS Item O4b, Antianxiety drug? And if so, would it be correct to explain the medication use in the care planning process?

Continue to code a medication for its classification not its use at MDS Item 04. In this case code Item O4 (antianxiety drug) as "7" days. Consider the drug's intended use, effectiveness and all potential side effects in the care planning process, and monitor accordingly.

Questions on Items in MDS Section P

QUESTION 3 - 71: We had a resident who received therapy 6 out of the 7 days in the observation period, totaling 65 minutes over the 6 days. The therapy session lasted 15 minutes on only one of those days. The sessions lasted 10 minutes each of the remaining 5 days. How should Item P1bA (number of DAYS administered for 15 minutes or more) and Item P1bB (total number of MINUTES provided in the last 7 days) be coded?

At MDS Item P1bA, record the number of days in the observation period that therapy was given for 15 minutes or more. In column P1bB, record the total number of minutes therapy was administered during the observation period, (even if it was less than 15 minutes on any of the days).

In the above scenario, only one day of therapy would be recorded at Item P1bA, since there was only one day in the observation period that the resident received at least 15 minutes of therapy. The entire 65 minutes should be recorded at Item P1bB.

The Item coding instructions appear on the form as well as in the RAI User's Manual, page 3-151.

QUESTION 3 - 72: Do the actual number of minutes of therapy provided to each resident have to be recorded at MDS Item P1bB (total number of minutes provided in the last 7 days)?

Yes. The Item description on the form, as well as the description and coding instructions in the RAI User's Manual, page 3-151, state to code the total number of minutes therapy was provided in the 7 day observation period. Time spent on documentation or on initial evaluation cannot be included. Time spent on periodic reevaluations conducted during the course of a therapy treatment, may be included.

QUESTION 3 - 73: How do I code MDS Items P1bA and P1bB when it is recorded in the therapy notes that the resident received 3 units of treatment and the number of minutes are not noted? Can we multiply the number of units by 15 minutes to determine the appropriate number of minutes to record on the MDS?

No. The MDS instructions clearly require reporting the actual minutes of therapy received by the patient. Historically, therapy units have been used for billing and have been derived from the actual therapy minutes. For MDS reporting

purposes, conversion from units to minutes is not appropriate, and the actual minutes should be obtained from the therapist's treatment logs. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may also be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS.

QUESTION 3 - 74: How would therapy minutes be coded at MDS Item P1bB under each of the following scenarios?

A) A licensed therapist works directly with 2 – 4 residents where each resident is performing the same modality, e.g., upper body strengthening. The treatment ends 30 minutes after it starts.

For each session, record 30 minutes therapy time for each resident at MDS Item P1bB. A maximum of 25% of the resident's therapy time can be delivered in groups.

B) A licensed therapist starts work directly with one resident to start them on a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get them started on a different task, while continuing to supervise the first resident. The treatment ends for each resident 30 minutes after it begins.

For each session, record 30 minutes therapy time for each resident at MDS Item P1bB.

C) Two licensed therapists, each from a different discipline, begin treating one resident at the same time. The treatment ends 30 minutes after it starts.

For each session, record 30 minutes total therapy time for the resident at MDS Item P1b. Split the time between the two disciplines as appropriate, for example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT at Item P1bA and 20 minutes of PT at Item P1bB. Also code the 10 minutes of OT in P1bB. In this example, no days may be coded for OT at Item P1bA, because the sessions only lasted 10 minutes.

QUESTION 3 - 75: When coding MDS Item P1bB, how would MDS minutes be determined when the therapist starts the session, and delegates the performance of the 30 minute therapy treatment to a therapy aide? The

therapist maintains line of sight supervision during the entire therapy session.

The services of aides performing therapy treatments may only be coded when the services are performed under line of site supervision by a licensed therapist. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. In the above scenario, include all 30 minutes of the therapy session in MDS Item P1bB.

QUESTION 3 - 76: Do therapists need to record the actual therapy minutes by modality on the therapy service logs? Is this required for MDS? For billing?

Documentation by HCPCS code (indicating the number of minutes per modality) is not required for MDS purposes. Report the total number of therapy minutes the resident received in the 7-day observation period.

When billing for Part A services, therapy units and dollars are reported by revenue code. It is not required to specify the modalities provided. However, when billing Part B therapy services to Medicare, it is necessary to show the specific CPT codes and units for each modality. Billing instructions for Part B therapy services can be found in Program Memorandum AB-01-56.

QUESTION 3 - 77: A facility provides maintenance therapy as described in section 214.3(e) of the Skilled Nursing Facility Provider Manual. The therapist establishes the program. As skilled service, the time spent developing the program is included on the MDS at Item P1b. Once the therapy aides are carrying out the established program, may the minutes of maintenance "therapy" that they provide be counted at MDS at Item P1b?

No. Once the licensed therapist has designed a maintenance program, and discharged the resident from the rehabilitation (i.e., skilled) therapy program, the services performed by the aide should no longer be reported on the MDS at Item P1b as skilled therapy. The services of the aide may be reported on the MDS as restorative nursing, at MDS Item P3, provided they meet the requirements for restorative therapy, i.e., documented measurable objectives, periodic evaluation by licensed nurse, etc.

There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice, but the minutes may not be reported on the MDS as skilled therapy.

QUESTION 3 – 78: Does a resident have to be covered by Medicare Part A in order to code MDS Item P1e (Monitoring acute medical condition)? Or conversely, should Item P1e be checked for all Part A covered beneficiaries?

No. According to the RAI User's Manual, page 3-149, Item P1e should be checked when a resident requires observation by a licensed nurse for ANY acute physical or psychiatric illness. This is a determination regarding the resident's clinical status. Payer source is not a factor. If a resident has a clinical condition that meets the coding criteria in the User's Manual, Item P1e should be checked whether or not the resident is covered by Medicare Part A.

QUESTION 3 - 79: Can the active or passive movement by the resident that is incidental to dressing, bathing, etc., count as active or passive range of motion when coding MDS Item P3?

No. The active or passive movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative care program. For inclusion at MDS Item P3, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures. Please consult the MDS User's Manual, page 3–153 – 3-157 for a complete description of a restorative care program.

QUESTION 3 - 80: We have a 'total care' resident who has no voluntary or involuntary movement. We place him in a Geri-chair to get him out of bed and out of his room. When he is in bed, we put the side rails up, and we don't consider them restraints or code them on the MDS. Should we code the Geri-chair as a "Chair Prevents Rising" at MDS Item P4e?

For a resident who has no voluntary or involuntary movement, the Geri-chair does not meet the definition of a restraint and should not be coded at Item P4e. While the bed rails may not constitute a restraint, they may affect a resident's quality of life. Bed rails become a visual barrier for these residents and may deter physical contact from others.

QUESTION 3 - 81: We have a resident who cannot walk, but is able to sit up in a Geri-chair. Should we code this at MDS Item P4e as a "Chair Prevents Rising"?

If the resident has the ability to transfer from other chairs, but cannot transfer

from a Geri-chair, the Geri-chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the Geri-chair does not meet the definition of a restraint, and should not be coded at Item P4e.

QUESTION 3 - 82: Can a resident, family member, legal representative or surrogate request that a restraint be used?

While a resident, family member, legal representative or surrogate may request that a restraint be used; the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative or surrogate has the right to refuse treatment but not to demand its use when it is not deemed medically necessary. According to the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), AThe resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. The guidelines in the State Operations Manual (SOM) state, A...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a legal surrogate or a representative's request or approval. The SOM goes on to state, AWhile Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatments that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions.

QUESTION 3 - 83: Does CMS prohibit the use of restraints or bed rails?

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing homes except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation states, AThe resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. Prior to using any restraint, the facility must assess the resident to properly identify the resident's

needs and the medical symptom that the restraint is being employed to address. The assessment must take into consideration the risks of using the device and the feasibility of employing an alternate, less restrictive means to accomplish the desired outcome. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a federal requirement, the use of restraints should be the exception, not the rule.

QUESTION 3 - 84: Does documenting that the side rail (partial or full) is used for positioning or to aid in mobility mean that the side rail is not a restraint?

Not necessarily. In classifying any device as a restraint, the assessor must consider the effect the device has on the individual - not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. If the side rail has the effect of restraining the resident, the facility is responsible to assess the appropriateness of that restraint. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The assessment must take into consideration the risks of using the device and the feasibility of employing an alternate, less restrictive means to accomplish the desired outcome. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at MDS Item P4 (a or b, as appropriate), *and* at MDS Item G6b (Bedrails used for mobility or transfer).

QUESTION 3 - 85: If a resident is immobile in bed, are side rails (partial or full) considered a restraint?

Physical restraints are defined as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, staff need to determine if there is any appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out

voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body toward the edge of the bed. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be done before employing the use of a restraint or side rail. While the bed rails may not constitute a restraint, they may affect the resident's quality of life.

QUESTION 3 - 86: When a Medicare Part A beneficiary returns from a hospital stay, a Medicare Readmission/ Return assessment is done. Are physician visits (Item P7) and physician orders (Item P8) counted from the date of the readmission, or would physician's visits and/or orders prior to or during the hospital stay also be included?

Count only those doctor's orders and/or visits since the date the beneficiary returned from the hospital. Do not count return admission orders, or renewal orders without changes.

QUESTION 3 - 87: Regarding MDS Items P7 and P8, what combinations of physician's visits and orders are used when calculating the RUG-III group?

Qualification for a RUG category requires the physician to have visited on at least one day during the observation period with order changes made on 4 or more days. If the physician visited on two or more days, the minimum number of days requiring order changes is reduced to 2.

QUESTION 3 - 88: How are MDS Items P7 (Physician Visits) and P8 (Physician Orders) coded when, in the observation period, the physician changes 2 orders in a single visit?

Physician order changes are tallied by the number of DAYS changes are made, not the number of orders changed. In the above scenario, MDS Item P8, (Physician Orders), should be coded "01", since the order changes all occurred on one day. Item P7, (Physician Visits), should be coded "01", since the physician visited one day during the observation period.

QUESTION 3 - 89: Which physician orders can be included when coding MDS Item P8 (Physician Orders)? For example, can we include the monthly Medicare Certification as an order?

A monthly Medicare Certification is a renewal of an existing order, and should not

be included when coding Item P8. The following instructions are excerpted from the RAI User's Manual, page 3 –161: "Physician orders — Includes written, telephone, fax, or consultation orders for new or altered treatment. This does NOT include admission orders, return admission orders, or renewal orders without changes."

QUESTION 3 - 90: When we provide service to a resident based on a PRN order, we notify the physician by preparing a phone order and ask the doctor to countersign it. Can we count this notification as a physician order when coding MDS Item P8?

No. Since the PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order, and may not be counted when coding Item P8.